AHCCCS

Arizona Health Care Cost Containment System
Arizona Long Term Care System

ANNUAL HCBS REPORT
CY 2006
(10/1/05 – 09/30/06)

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Prepared by
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www.azahcccs.gov

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(10/01/2005 – 09/30/2006)

INTRODUCTION

The Arizona Health Care Cost Containment System (AHCCCS) Administration has implemented a long-term care program through the Arizona Long Term Care System (ALTCS) that strongly supports the opportunity for individuals enrolled in the ALTCS program to live in home and community based service (HCBS) settings.

The AHCCCS Administration has done this through a program that promotes the values of:

- Choice
- Independence
- Self-determination
- Dignity
- Individuality

Guiding principles have also been established with the belief that every effort should be made to support the ability of individuals to reside in HCBS settings. These guiding principles are as follows (see attachment A):

- Member-Centered Case Management
- Accessibility of Network
- Collaboration with Stakeholders
- Consistency of Services
- Most Integrated Setting

Members and families are afforded the opportunity to actively participate in the process to select the services that will best meet their needs. HCBS and the applicable settings are available to an individual as long as these services cost no more than what nursing facility services would cost.

Both the AHCCCS Administration and its Program Contractors have operationalized these principles by emphasizing the development and maintenance of services and settings that provide for consistent growth of the percentage of consumers who are able to live in the community.

Contract Year Ending 2006 (CY 2006) saw another year of slow but continued growth of the percentage of members living in HCBS settings. This is the fifth consecutive year that statewide growth showed a slower growth rate when compared to previous years. This slower growth rate continues to be expected, given that those remaining in nursing facility placements will require even greater creativity and network development efforts to successfully transfer their care to HCBS settings. The slowing of the growth will bring new challenges in the coming years. At the same time it will bring opportunities to look more closely at ways to effectively allow people to remain in their own homes.

In consideration of those challenges the AHCCCSA included several HCBS initiatives in its ALTCS Elderly and Physically Disabled (E/PD) Request for Proposal (RFP) that was issued on February 8, 2006, and awarded in May 2006. These initiatives included

coverage of HCBS during prior period coverage, transition services to assist members transferring from nursing facilities to their own home, consumer directed care and HCBS paraprofessional workforce development. These programs, which are currently being developed, will form the foundation of future innovations in providing HCBS services to ALTCS members.

The information that follows details the experiences for CY 2006 and future initiatives to improve upon the quality and expansion of HCBS.

SIGNIFICANT HCBS ACTIVITIES

The following is a summary of the more significant HCBS related activities undertaken by the Program Contractors and the AHCCCS Administration.

- *Olmstead Plan*

  Arizona's Olmstead Plan was completed in August 2001 and the workplan status updated March 2003. Much of the Plan's focus is on actions Arizona can take to improve the availability and accessibility of HCBS and settings. Examples include payments to assist transition to HCBS, spouses and parents as paid caregivers, pay increases for HCBS paraprofessional caregivers and consumer directed services.

  HCBS during prior period coverage and paraprofessional workforce development was implemented October 1, 2006. Transition services to assist members transferring from nursing facilities to their own home, consumer directed care and allowing a spouse to be a paid caregiver are planned for an October 1, 2007 implementation. The Olmstead Plan and the workplan are available on the AHCCCS web page. A copy of the report can be found at www.ahcccs.state.az.us/Publications/Plans/Olmstead/default.asp.

  The AHCCCS Administration increased the HCBS fee-for-service rates by 4.5% and incorporated this increase into the Program Contractor capitation rates that were effective 10/10/06.

- *Member-Provider Councils*

  Each Program Contractor is required to have a Member-Provider Council which includes representation by consumers/families/significant others, advocacy groups and providers. The Councils' representation is to reflect the population and communities they serve. The purpose of the Councils is to promote a collaborative effort to enhance the service delivery system in local communities, with special emphasis on home services and input on policies that affect members and providers. AHCCCS reviews the agendas, minutes, and schedules of all Member-Provider Council meetings. AHCCCS also reviews the Program Contractor Annual Plans for the Council, which outlines strategies and direction for the year. In reviewing the minutes of the meetings, AHCCCS has noted that stakeholders are providing valuable input regarding support for both acute and HCBS services. Key areas where Councils have assisted Program Contractors with feedback and suggestions have been: 1) review of proposed member educational materials, 2) suggestions for adding providers to the network, 3) member survey suggestions, 4) formulary additions, and 5) disease management.

  Program Contractors also have implemented innovations to enhance member attendance at the Council meetings. Meals are offered to members and their attendants by some Program Contractors. Another holds its meetings at different

sites, such as senior centers, nursing facilities, etc. One rural Program Contractor holds meetings in both the population centers of its county on consecutive days.

- *Network Development Plans*

AHCCCS requires that Program Contractors develop Network Development and Management Plans. The purpose of these plans is to identify the current status of the network at all levels (institutional, HCBS, acute, alternative residential, etc.) and to project future needs based upon membership growth and changes in member profiles/service needs. The Plan requires the Program Contractor to develop information on the following:

- Evaluation of the previous year's plan
- Current status of network
  - ✓ how members access the system
  - ✓ relationship between the various levels of the networks
- Current network gaps
- Immediate short term interventions when a gap occurs
- Interventions to fill network gaps, and barriers to those interventions
- Outcome measures/evaluation of interventions
- Ongoing activities for network development
- Coordination between contractor departments and outside organizations, including member/provider councils
- Specialty populations
- Membership growth/changes
- A description of the adequacy of the geographic access to tertiary hospital services

AHCCCS evaluated the plans that were submitted for CY 2006. Overall, the plans presented proper analysis of the network and network gaps. It is significant to note that since requiring the development of Network Management and Development Plans:

1. Program Contractors have instituted more formalized processes in analyzing their networks including the development of network operation teams. These teams meet regularly to analyze the networks needs and status of current network plans. Team members include case management, quality management, utilization management, finance and the medical directors. Emphasis in these meetings is placed on feedback received from direct line staff (i.e., case managers, Member-Provider Councils, providers) to drive the initial stages of network analysis. This allows Program Contractors to respond more quickly to both potential short and long term network needs. During CY 2006 several Program Contractors used the results of this analysis to enhance their transportation services for dialysis patients and persons with behavioral health needs.

2. All Program Contractors now have a formalized process to include their Member-Provider Councils feedback and/or suggestions in their Network Development and Management Plans. Of particular importance has been Council input on provider education regarding the ALTCS Program, as well as identification of potential new providers in an area.

3. Rural Program Contractors, who face unique challenges in program and service development, have developed several methods to increase their networks. Among these are: 1) use of the Medical Director in recruiting for paraprofessional services, 2) partnering with other community advocacy groups to contract with home modification providers, and 3) use of the website to keep members informed of changes in the network.

4. Program Contractors are discussing network needs in the distant future as opposed to merely reacting when a network gap occurs. This includes reviewing population trends in their services areas.

- *Caregiver and Workforce Development*

In March of 2004 Governor Napolitano formed a Citizens' Workgroup on the Long Term Care Workforce. The purpose of the Workgroup is to study the issue of the direct care workforce and provide recommendations to the Governor regarding potential strategies to improve the workforce. The Workgroup issued a report April 2005. A copy of the report can be found at: http://www.azahcccs.gov/Contracting/BiddersLibrary/ALTCS/Reference/CWGReport_Final_June2005.pdf

AHCCCSA's response to this report was to include paraprofessional workforce issues in the ALTCS RFP that was released February 2006. Since ALTCS makes up the largest payer group for paraprofessionals in the long-term care market, the Program Contractors are required to have as part of their network development plan a component regarding paraprofessional work force development in nursing facilities, alternative residential facilities and in-home services (attendant care, personal care and homemaker). Successful efforts to recruit, retain and maintain a long-term care workforce are necessary to meet the needs of the anticipated growth in the ALTCS membership.

The AHCCCSA defines Work Force Development as all activities that increase the number of paraprofessionals participating in the long-term health care workforce. It includes actions related to the active recruitment and pre-employment training of new caregivers and opportunities for the continued training of current caregivers (i.e. Program Contractor supported/sponsored training). Work Force Development also includes efforts to review compensation and benefit incentives, while providing a plan for the expansion of the paraprofessional network at all levels of client care.

- *Interagency Council on Long-Term Care*

  In 2001, legislation was passed to create the Interagency Council on Long-Term Care. The purpose of the council is "to help the state achieve a coordinated long-term care services delivery system." Additionally, the council is required to "define this state's long-term care obligations by coordinating applicable state and federal mandates that relate to long-term care services." Representation on the council includes legislators, several state agencies and several advocacy agencies.

  The Council has been involved with two primary projects over the past year. One has been to establish a "core curriculum" for the paraprofessional workforce. A curriculum has been developed for caregivers providing services to people who are elderly and/or physically disabled. Additional curriculums are being developed for caregivers who provide services to people with developmental disabilities and dementias.

  The other workgroup that has been established is a steering committee for Arizona's Aging and Disability Resource Center (ADRC) grant. The grant is being administered by the Department of Economic Security, Division of Aging and Adult Services. The AHCCCS Administration is taking an active role at all levels in the establishment of the Arizona ADRC.

- *Program Contractor Efforts and Innovations*

  ALTCS Program Contractors have developed numerous innovative methods to enhance the lives of HCBS members and their caregivers. Most have developed methods to bring services into the members' home that members traditionally had to travel to receive. In-home physician and nurse practitioner visits are offered by three Program Contractors. Others bring radiology, lab services, behavioral health counseling, psychiatry, and physical therapy to homes. One rural Program Contractor sent staff nurses to member homes to provide influenza and pneumococcal immunizations. Several contractors now have a mail order pharmacy delivery system. All have disease management programs which target members with certain diagnoses for enhanced clinical oversight, including more frequent tests, nursing visits, and lifestyle change advice. Others have staff dieticians and physical therapists that visit homes to assess member needs and provide consultation.

  It is frequently difficult for rural Program Contractors to find construction contractors willing to perform home modifications. These contractors often demand advance payment or are unwilling to obtain registration as a Medicaid provider. Two Program Contractors have teamed with other agencies in their areas to recruit home modification providers and assist them in overcoming paperwork issues in registration and claims payment.

Treating members and families in a culturally sensitive manner can have a positive effect upon efforts to support individuals in the community. Most Program Contractors have assigned bilingual case managers to Spanish speaking only caseloads. This has resulted in decreased barriers to placement in the Hispanic community. One Program Contractor hired a Russian speaking interpreter when it noticed a growing enrollment of Russian speaking members. A Program Contractor in Maricopa County has noticed an upsurge in membership of persons of Southeastern Asian heritage, and is reviewing its network as a result.

- *Behavioral Health Workgroups*

Arizona State Hospital Workgroup

Every six weeks the ALTCS Program Contractors meet with AHCCCS staff, staff of the Arizona State Hospital and the Arizona Center for Disability Law. These meetings are held to discuss discharge plans for the most difficult clients currently residing as inpatients at the facility. These clients typically not only have severe behavioral problems, which necessitate specialized community placements, but also serious and chronic medical conditions. Virtually all have been admitted to the hospital on court orders. Despite the challenges of these members with their complex issues, placement in the community can be appropriate and recidivism has been rare. Among the HCBS settings these members reside in are small group homes dedicated to members with like behaviors, such as excessive fluid consumption. Other homes include single person residences with in-home services. New programs for hyper-aggressive dementia patients are being developed, as are more traumatic brain injury facilities.

AHCCCS/ Regional Behavioral Health Authority Meeting

Meetings are held monthly with representatives from Value Options, the Regional Behavioral Health Authority, ADHS/Division of Behavioral Health Services, the Program Contractors in Maricopa County, and AHCCCS to discuss the transition of members from the acute program to the long term care program. The goal of the group is to ensure that members receive uninterrupted behavioral health care in the most integrated settings, including HCBS when transitioning from one Title XIX program to another.

Desert Vista Hospital Meeting

Representatives from Desert Vista psychiatric hospital, ADHS/Division of Behavioral Health Services, AHCCCS, the Center for Disability Law, the Division of Developmental Disabilities, and the Program Contractors in Maricopa County meet on a monthly basis to discuss members who are currently ALTCS-eligible or who have applied for long term care services and are receiving inpatient services from this facility. Discussions focus on the member's placement needs with the goal to divert them from placement in the Arizona State Hospital while maintaining their stability in the most integrated settings, including HCBS.

Behavioral Health Subgroup

Program Contractor Behavioral Health Coordinators and other representatives have elected to form a subgroup in which the day to day operations of serving members with behavioral health needs are discussed. The subgroup meets on a quarterly basis and has already initiated discussion around the sharing of networks in order to meet their members' individual/unique needs. Additional topics for future discussion include approaching community providers as a group, in effort to enhance the availability of community placement opportunities.

- *Performance Measures*

AHCCCS reports Performance Measures specific to the ALTCS elderly and/or physically disabled (E/PD) population. These measures include three indicators of diabetes care and a measure of the timeliness of services for members in home and community-based settings.

Diabetes Care

The potential impact of diabetes on the Arizona Long Term Care System (ALTCS) is of significant concern to AHCCCS. Complications of diabetes can affect the ability of many E/PD members to remain in their homes or a less intensive community-based setting.

AHCCCS submitted a complete report of the Diabetes Performance Measures to CMS prior to the November 1, 2006, due date. These measures include ALTCS members in HCBS settings, as well as those in Nursing Facilities. Data are derived from AHCCCS encounters and from medical records.

For the measurement period of CYE 2005, AHCCCS overall rates for Hb A1c testing and lipid screening remained at about the same level as for the previous measurement period. The rate for retinal exams increased markedly in this measurement, and is above the 90th percentile for Medicaid plans nationally.

Initiation of Home and Community Based Services

The report of this Performance Measure was submitted to CMS prior to the August 1, 2006, due date. The intent of this study is to measure the health care services that primarily allow members at risk of institutionalization to remain in their homes or the community.

The study sample included 566 HCBS members. Of those, 173 people were residing in assisted living facilities, were admitted to hospitals or nursing facilities, were receiving hospice services, or refused services within 30 days of enrollment. Among the remaining 393 people, 350 or 89.1 percent received services within 30 days of enrollment.

AHCCCS continues to monitor Contractor quality-improvement activities related to these measures, through submission of annual Quality Assessment/Performance Improvement Plans. AHCCCS provides educational support and technical

assistance to ALTCS Contractors to help them improve rates of utilization of services such as Hb A1c testing of diabetics. During CYE 2006, AHCCCS also provided education and technical assistance to Contractors on strengthening disease management programs and care coordination activities to improve health outcomes.

- *Performance Improvement Projects*

In CYE 2006, AHCCCS had the following Performance Improvement Projects (PIPs), which included HCBS members, under way:

Diabetes Care

Through this PIP, AHCCCS is working with Contractors to improve the rate of annual HB A1c testing, as well as reduce the rate of "poorly controlled" blood glucose (Hb A1c levels greater than 9.5 percent). Contractors implemented interventions such as developing practice guidelines for diabetes care, offering educational sessions to providers and members/families, and utilizing disease management and case management programs to improve Hb A1c testing and levels among diabetic members.

All health plans have sustained improvement under this PIP and submitted final reports to AHCCCS, which identify interventions used during the PIP, describe how the improvements can be reasonably attributed to interventions, and discuss the extent to which the PIP was successful and any improvements in processes or ongoing activities related to the PIP. AHCCCS has posted its final report on the project to its website.

Management of Comorbid Diseases

In CYE 2004, AHCCCS initiated a PIP focusing on improving management of HCBS members who have two or more coexisting diseases. The purpose of the project is to prevent the onset of additional diseases and/or reduce the effects of comorbid diseases already present by improving case management and care coordination services. This is expected to improve the likelihood that HCBS members remain in their homes or an alternative community setting longer and delay institutionalization. As part of this project, ALTCS Contractors will attempt to improve care coordination with Medicare providers and Medicare Advantage Plans for their dual-eligible HCBS members. AHCCCS' Medical Management unit also has been providing Contractor education on improving disease management programs.

AHCCCS established baseline measurements for inpatient days, emergency department or urgent care visits and outpatient/physician visits for members selected for this study. The first remeasurement was collected in CYE 2006, and is being analyzed. Preliminary reports from ALTCS Contractors indicate that they have improved disease management and care coordination processes for their HCBS members.

- *Alzheimer's Pilot Program*

  The ALTCS Alzheimer's Pilot program (pilot) was initiated by the Arizona Legislature in October 1999 to pay qualifying assisted living facility providers to care for ALTCS members with Dementia related diagnoses.

  Since that time participation by both members and provider facilities has gradually increased. By the end of 2006 there were approximately 225 members and 15 facilities participating in the pilot, mostly in Maricopa County.

  The pilot was scheduled to end on September 30, 2005. AHCCCS did not feel that this pilot needed to be continued because AHCCCS regulations now allow any Arizona Department of Health Services (ADHS) licensed Assisted Living Center to become a registered AHCCCS provider and contract with an ALTCS Program Contractor. The Arizona Alzheimer's Association, however, felt further legislation or other regulation was necessary to ensure the staffing mandated by this pilot, that is not mandated by licensure requirements (6:1 during the morning and evening hours and 12:1 during the night), be maintained. The Association introduced legislation to extend the pilot for another 2 years while Assisted Living Facility licensure rules were reviewed. The pilot was extended by the Legislature through December 31, 2007.

  Data collected by AHCCCS regarding the ALTCS Contractors' costs for members in the pilot facilities has continued to show this type of placement is cost effective when compared to the costs of other settings appropriate for members with Dementia, primarily nursing facilities. In addition, families of members in the pilot who have been surveyed expressed overall satisfaction with the quality of care received in these settings.

- *Ball v. Biedess (Rodgers)*

  The AHCCCSA has been involved with a class action lawsuit for several years concerning the availability of in-home services to ALTCS members. It was alleged that ALTCS members were not being provided HCBS in the amount necessary to allow members to live in their own home. The U.S. District Court for the District of Arizona decided in the plaintiff's favor and issued final orders June 2005. Ball v. Biedess (Rodgers) as the case is known requires the AHCCCSA to eliminate all gaps in critical in-home services within two hours of the gap being reported. Critical services include Attendant Care, Personal Care, Homemaker and Respite services.

  Implementation of the order began August 2005. All ALTCS members receiving in-home services were notified in writing of their rights under this order. Case Managers met with members and/or representatives to develop written contingency plans so that they would understand what steps to take in case of gaps in critical services. The AHCCCSA is now collecting monthly service gap information from the Program Contractors. Gaps in critical services are currently averaging approximately 5 to 7 hours for every 10,000 hours of authorized services.

An AHCCCSA appeal of the case is pending before the U.S. Court of Appeals for the Ninth Circuit.

- *Prior Period Coverage For HCBS Services*

The recently awarded RFP, starting in October 2006, includes coverage of HCBS services for Prior Period Coverage enrollment. This will allow applicants to have HCBS services covered by the Program Contractor during the period between application and determination of eligibility. Such coverage will allow greater flexibility in choice of service site. Previously such coverage was limited to acute care services and nursing facility services. Persons awaiting discharge from hospitals will now be able to go home, with coverage of those services paid for once eligibility is determined and enrollment is complete.

- *Consumer Directed Care*

The AHCCCS Administration is intending to implement a Consumer Directed Care (CDC) model program for implementation beginning October 1, 2007. CDC is a philosophy and approach to the delivery of home and community based services in which informed members make choices about the types of services they will receive and by whom and when the service is to be delivered. Consumer responsibilities typically considered key to consumer direction include: 1) recruiting, hiring and training caregivers, 2) defining the caregiver's duties and work schedule, 3) supervising the caregiver in specific tasks, 4) managing payroll and tax functions, 5) providing performance feedback and 6) retraining, disciplining and firing the caregiver if his or her work is unsatisfactory. A fiscal intermediary model, an agency handling the payroll, taxes and other defined requirements, would be utilized since consumers can not receive Title XIX funding directly for services.

Pinal/Gila Long Term Care is the lead Program Contractor for the development of the CDC program. Memberships on the steering committee and various workgroups are represented by consumers, advocates, providers, other program contractors and AHCCCSA.

- *Transition Services*

The AHCCCS Administration intends to implement Transition services effective October 1, 2007. Transition services will be utilized to assist the transfer of institutional members to in-home settings. Transitional services are generally intended to provide for basic household necessities (cookware, furniture, security deposits, utility setups, etc.). The Administration has established a workgroup with representation from Program Contractors, consumers and advocates. The workgroup will address coverage issues related to scope of coverage, expenditure and frequency limitations and provider standards.

HCBS GROWTH AND PLACEMENT TABLES AND GRAPHS

The following six pages contain tables and graphs that show the growth of the ALTCS elderly and physically disabled population over several time periods. These tables and graphs are accompanied by a description.

- Table 1 and Graph 1 — Statewide Placement and Percentage by Setting (January 2000-January 2007)
- Graph 2 — Percentage of Growth by Setting (January 2000-January 2007)
- Graph 3 — HCBS Placement Percentages by Program Contractor (2001, 2002, 2003, 2004, 2005, 2006)
- Table 2 and Graph 4 — Alternative Residential Setting Placement Status (2001, 2002, 2003, 2004, 2005, 2006)
- Table 3 and Graph 5 — Placement By Age Group By HCBS, ALF and Institutional (2006)
- Table 4 — Elderly and Physically Disabled Placement by Program Contractor (2006)

Table 1 and Graph 1
Statewide Placement and Percentage by Setting

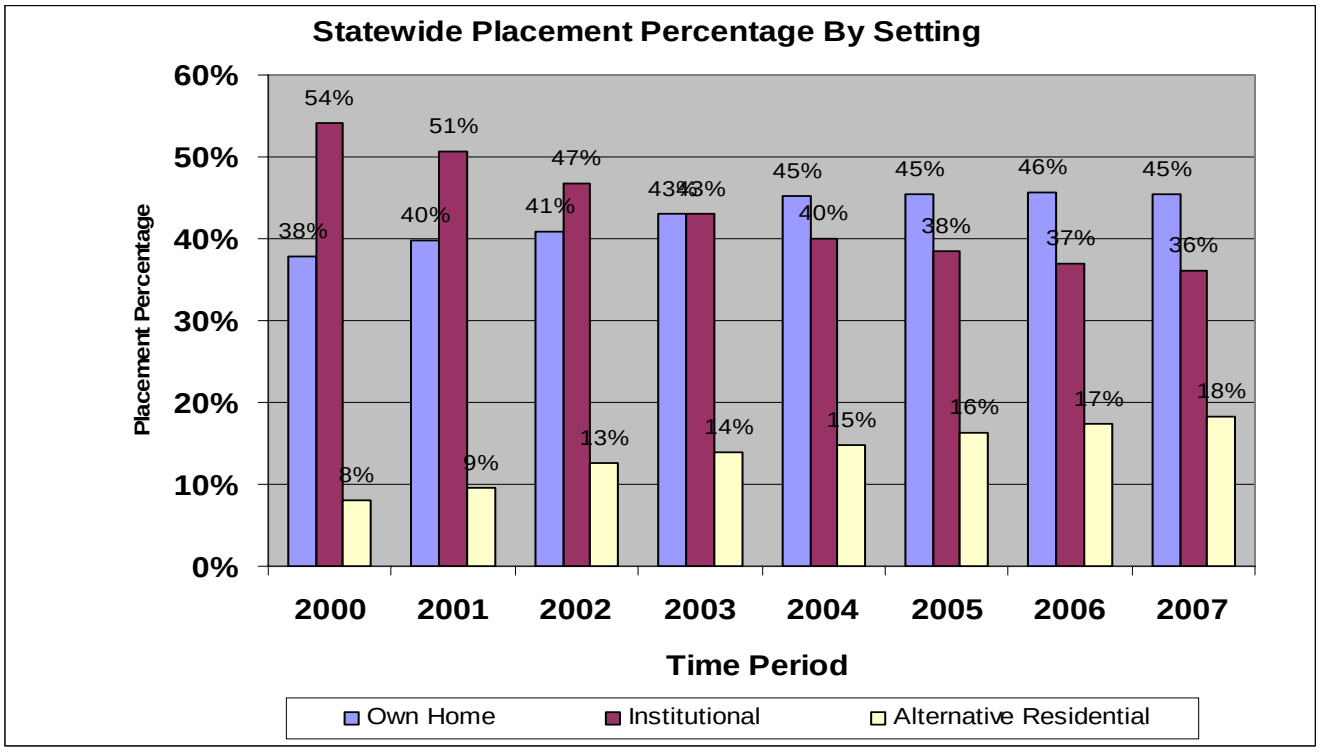
Table 1 and Graph 1 show the growth of the ALTCS elderly and physically disabled (EPD) population from January 2000 through January 2007. Of particular interest is that the number of Institutional members in January 2007 is less than January 2000. Graph 1 shows the distribution of members between Own Home, Alternative Residential and Institutions. The proportion of members residing in Alternative Residential settings increased over the last year from 17% to 18%. The proportion of members residing in their own homes decreased to 45%. The proportion of the members residing in Institutions declined to 36% in 2007.

Table 1

Statewide Placement By Setting

	Placement Jan-00	Placement Jan-01	Placement Jan-02	Placement Jan-03	Placement Jan-04	Placement Jan-05	Placement Jan-06	Placement Jan-07
Own Home	6,259	6,632	7,573	8,582	9,473	10,030	10,173	10,092
Alternative Residential	1,311	1,574	2,326	2,779	3,076	3,582	3,879	4,079
Institutional	8,939	8,425	8,654	8,591	8,387	8,504	8,204	8,037
Total	16,509	16,631	18,553	19,952	20,936	22,116	22,256	22,208

Graph 1

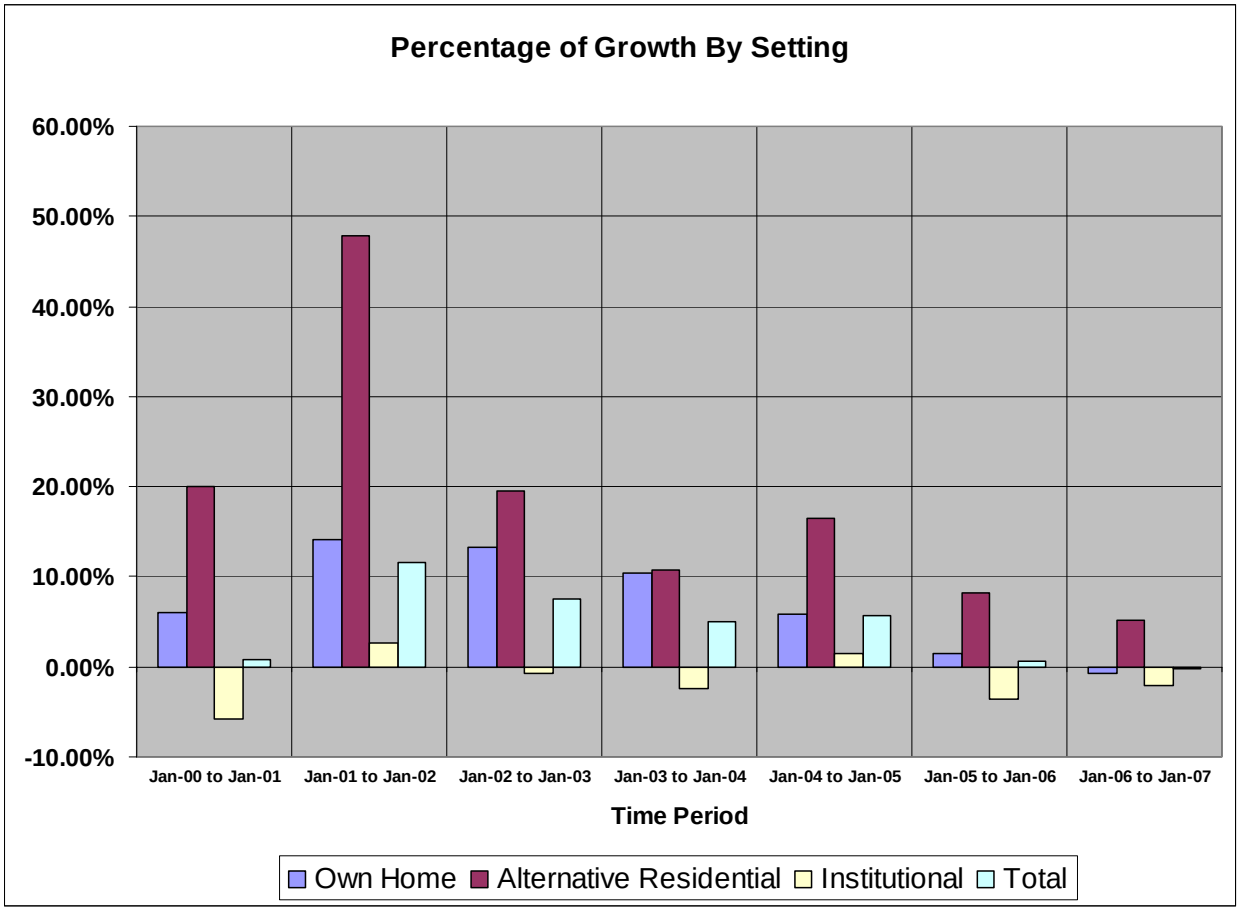


Graph 2

Percentage of Growth by Setting

Graph 2 takes the information from Table 1 and shows the percentage of growth that each type of setting has experienced since January 2000. Alternative Residential settings were the only placement group to have any growth for the latest reporting period, January 2007. The overall ALTCS population, HCBS and NF all experienced declines. No specific reasons have been identified to explain the decrease in ALTCS enrollment.

Graph 2



Graph 3
HCBS Placement Percentage by Program Contractor

This graph shows the HCBS placement growth by Program Contractors for the last six contract years. Two of the Program Contractors experienced declines. Mercy Care Plan's decline was due to taking on half of the members enrolled with Maricopa Long Term Care Plan. Maricopa County Long Term terminated their contract with AHCCCS effective October 1, 2005. Yavapai County Long Term Care's decline may be due to the continuing decline of ALTCS enrollment in Yavapai County. It is expected that the overall HCBS growth will continue.

Graph 3

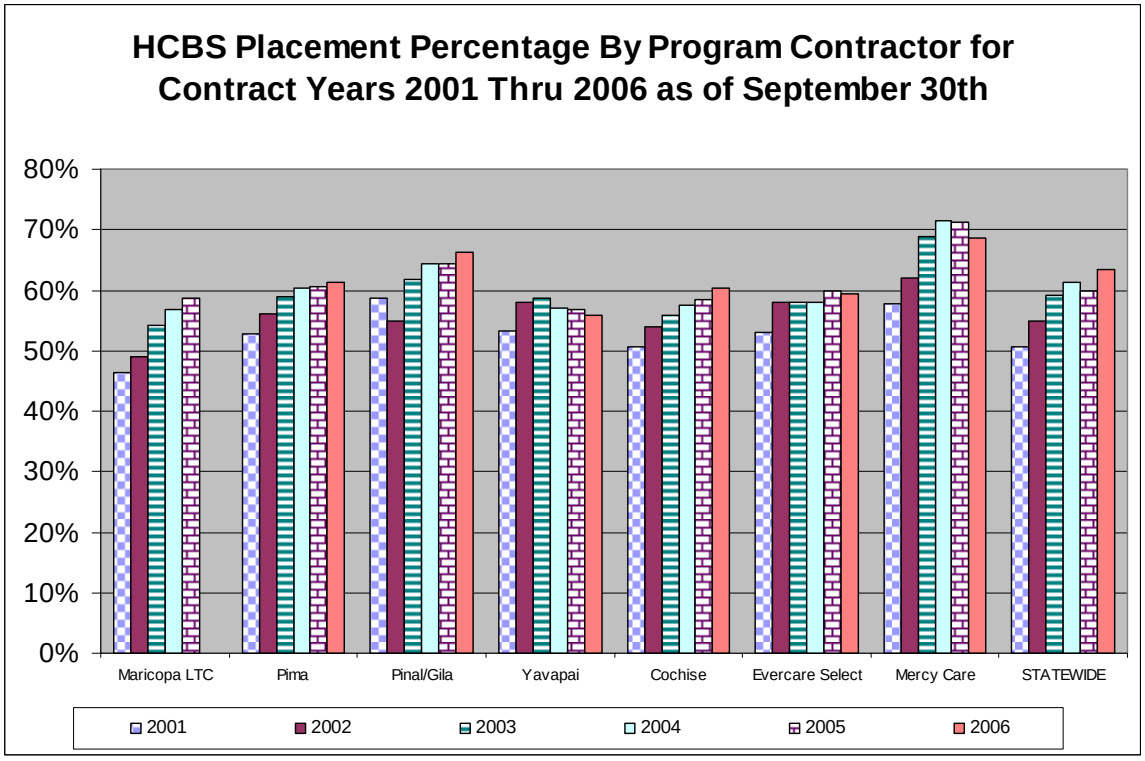


Table 2 and Graph 4
Alternative Residential Setting Placement Status

Table 2 and Graph 4 show the growth and distribution of the members who reside in the different alternative residential placements, including those with a behavioral health license. Adult Foster Care (4 or less beds) has shown a continued decline both in number of people residing and the proportion of people residing in this setting. Assisted Living Centers continue growth in both percentages and numbers of members residing there. As previously noted in Table 1, Graph 1 and Graph 2 there has been continuous growth in alternative residential placements overall.

Table 2

Alternative Residential

	CYE 01		CYE 02		CYE 03		CYE 04		CYE 05		CYE 06	
PLACEMENT	#	%	#	%	#	%	#	%	#	%	#	%
Adult Foster Care	515	23.71%	482	17.64%	447	14.75%	440	12.62%	400	10.51%	345	8.55%
Assisted Living Center	796	36.65%	1,096	40.12%	1,274	42.05%	1,540	44.18%	1,788	46.98%	2,069	51.29%
Assisted Living Home	755	34.76%	1,044	38.21%	1,211	39.97%	1,407	40.36%	1,520	39.94%	1,508	37.38%
Behavioral Health	106	4.88%	110	4.03%	98	3.23%	99	2.84%	98	2.57%	112	2.78%
TOTAL	2,172	100.00%	2,732	100.00%	3,030	100.00%	3,486	100.00%	3,806	100.00%	4,034	100.00%

Graph 4

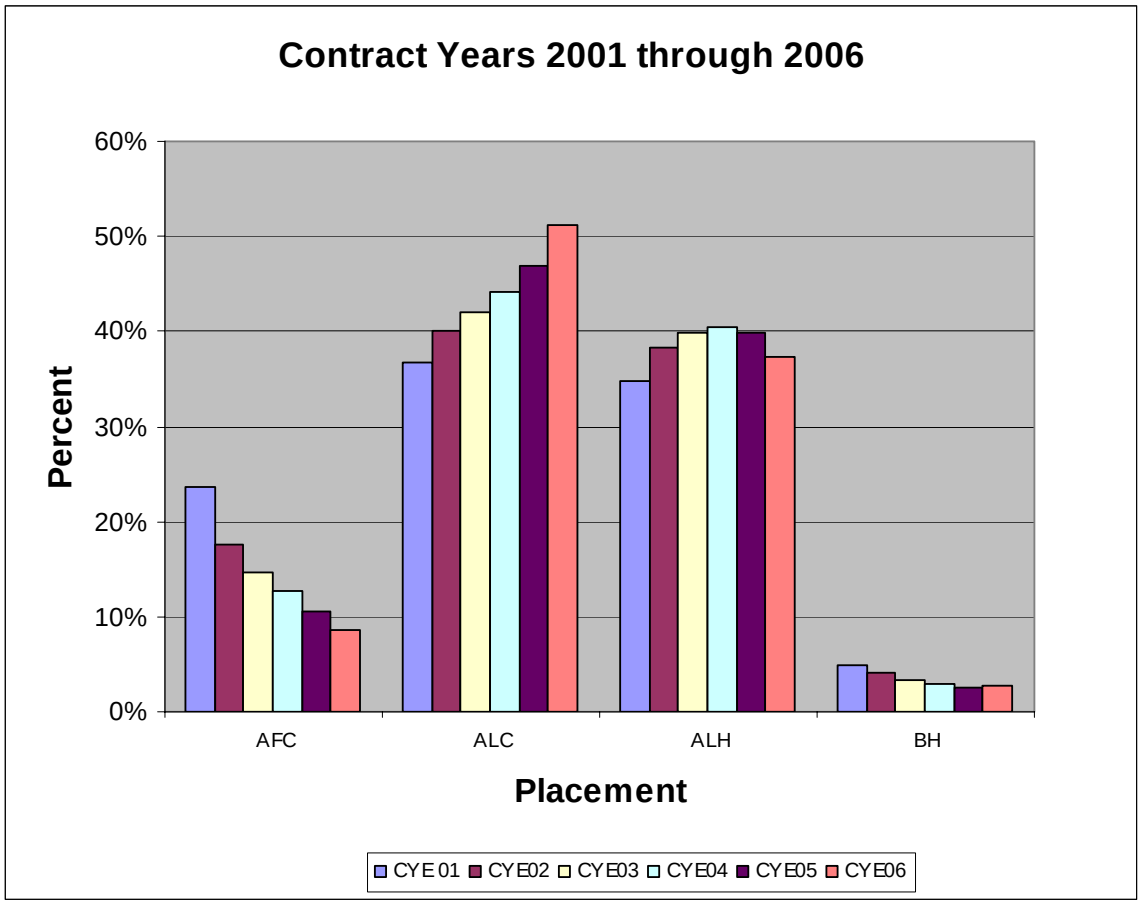


Table 3 and Graph 5
ALTCS EPD Placement by Age Group

This table and graph present information on the difference in member placement based on three age groupings (0 - 20, 21 - 64 and 65 plus). As expected, members in the 65 years and older age group have the highest proportion residing in institutional settings (43%). The 0 – 20 year age group has the lowest proportion of members residing in institutional settings (2%). Only 24% of members 21 – 64 years of age reside in institutional settings.

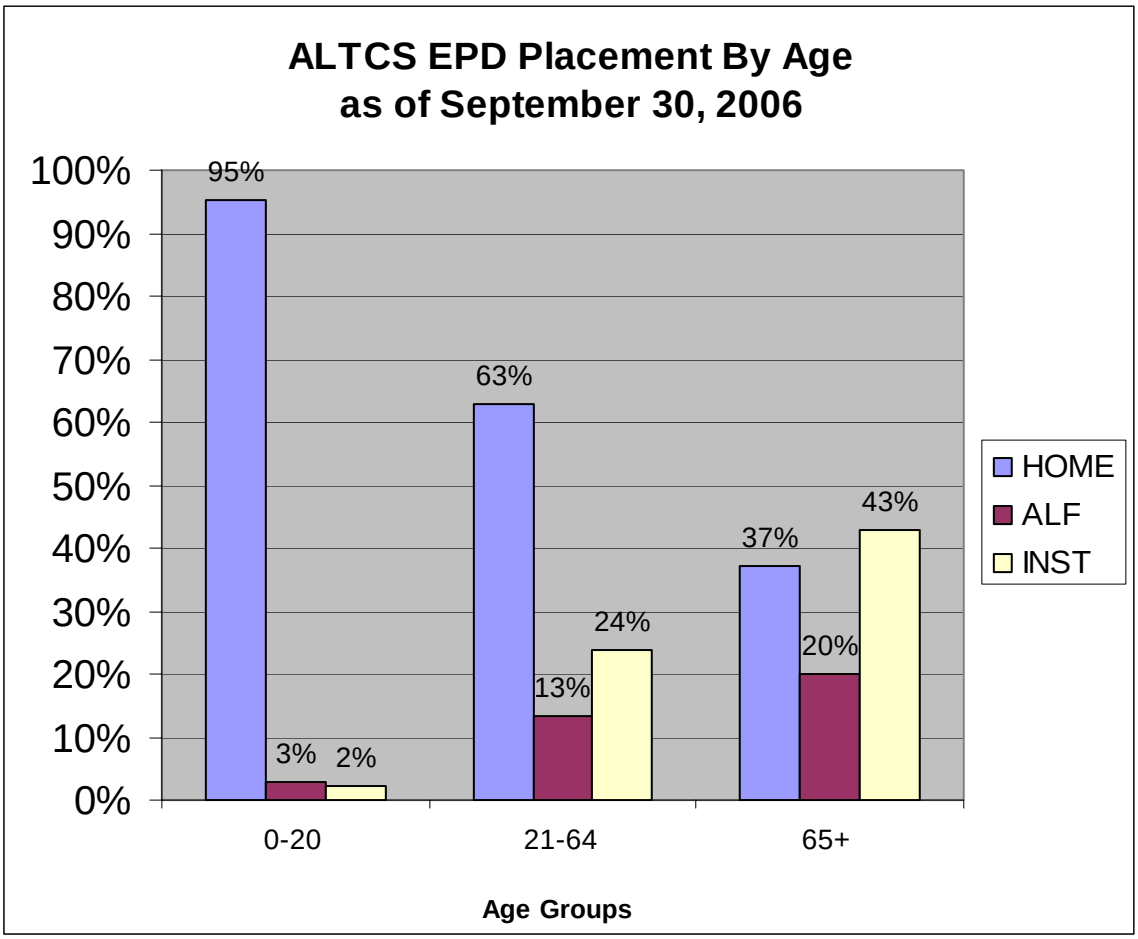
Table 3

ALTCS EPD Placement by Age Group as of September 2006

Does not include Not Placed and Acute Members

	0-20	21-64	65+	TOTAL
HOME	448	3,845	5,841	10,134
ALF	13	813	3,168	3,994
INST	10	1,466	6,721	8,197
TOTAL	471	6,124	15,730	22,325

Graph 5



ELDERLY AND PHYSICALLY DISABLED PLACEMENT BY PROGRAM CONTRACTOR
REPORT AS OF 9/30/2006

The table below shows the number of members placed in the various settings at the end of the Contract Year 2006
The Numbers represent placement by Program Contractor.

	ALTERNATIVE RESIDENTIAL									
Program Contractor	**Own Home**	**AFC**	**ALC**	**Behavioral Health**	**ALH**	**Total Alternative Residence**	**Nursing Facility**	**Acute**	**Not Placed**	**COMBINED TOTAL**
Cochise Health Systems	483	1	33	0	33	550	362	6	12	930
Evercare Select	2,410	38	844	21	718	4,031	2,754	66	56	6,907
Mercy Care Plan	4,327	224	885	73	287	5,796	2,649	165	94	8,704
Pima Long Term Care	1,726	67	178	10	384	2,365	1,500	42	52	3,959
Pinal/Gila Long Term Care	691	0	50	7	61	809	412	9	8	1,238
Yavapai Long Term Care	417	4	79	1	25	526	417	10	7	960
Total EPD Population	10,054	334	2,069	112	1,508	14,077	8,094	298	229	22,698

Attachment A: ALTCS Guiding Principles

- *Member-Centered Case Management*

The member is the primary focus of the ALTCS program. The member, and family/significant others, as appropriate, are active participants in the planning for and the evaluation of services provided to them. Services are mutually selected to assist the member in attaining his/her goal(s) for achieving or maintaining their highest level of self-sufficiency. Information and education about the ALTCS program, their choices of options and mix of services should be accurate and readily available to them.

- *Consistency of Services*

Service systems are developed to ensure a member can rely on services being provided as agreed to by the member and the Program Contractor.

- *Accessibility of Network*

Access to services is maximized when they are developed to meet the needs of the members. Service provider restrictions, limitations or assignment criteria are clearly identified to the member and family/significant others. Service networks are developed by the Program Contractors to meet members' needs which are not limited to normal business hours.

- *Most Integrated Setting*

Members are to be maintained in the least restrictive setting. To that end, members are afforded choice in remaining in their own home or choosing an alternative residential setting versus entering into an institution.

- *Collaboration With Stakeholders*

The appropriate mix of services will continue to change. Resources should be aligned with identified member needs and preferences. Efforts are made to include members/families, service providers and related community resources, to assess and review the change of the service spectrum. Changes to the service system are planned, implemented and evaluated for continuous improvement.